

Child History Form

Name: _____ Date: _____

Please complete this detailed history form and return it. If you need any assistance please let us know.

CHIEF HEALTH CONCERNS: _____

LIST OTHER CARE FOR THIS COMPLAINT: _____

Date of onset ____/____/____ Onset was (circle): Sudden/ Gradual/ Associated with event

Duration of current episode: _____ min./ Hr./ days/ months/ years

Pattern of problem (circle): Constant / Intermittent / Occasional / Cyclical

Associated Event: _____

Aggravating Factors: _____

Relieving Factors: _____

Effects of problems on the body function and daily activities: _____

Prior occurrences: _____

Other health concerns: _____

History of Birth

Where was your child born (Hospital/ Facility/ Home/ ect.): _____

Who assisted (Doctor/ Midwife/ Doula): _____

Length of pregnancy: _____ weeks Length of delivery: _____ hours

Was delivery assisted: forceps / vacuum extraction/ c-section/ labor induced/ Other: _____

Medications delivered to Mother around birth: _____

Complications at birth: _____

APGAR (if known): _____ Birth weight: _____ Birth length: _____ Delivery normal: Yes or No

Growth and Development

As an infant was the child responsive within 12hrs. of delivery: Yes or No explain: _____

At what age did the child: Respond to sound: _____ Follow Objects: _____ Hold head up: _____

Vocalize: _____ Sit unaided: _____ Teethe: _____ Crawl: _____ Walk: _____

Do the child's sleeping patterns seem normal: Yes or No explain: _____

Chemical Stressors

Was the child breast fed: Yes or No How Long: _____ Formula introduced at what age: _____

Type of formula used: _____ Cow's milk introduced at what age: _____

Age introduced & Type of baby food: _____

Age introduced & Type of solid food: _____

Food/Juice intolerance Y/N explain: _____

During pregnancy did the Mother SMOKE: Yes or No ; DRINK Yes or No ; Have any illnesses: _____

_____ ; Take any supplements: _____

Take any drugs: _____

During the pregnancy was the child exposed to ultrasound Yes or No. How many _____ and

what was the medical reason _____ ; any

invasive procedures (amniocentesis, CVS) _____ ?

Are there any pets at home Y/N? Type: _____

Has the child been vaccinated Y/N? Which ones _____ and

Where there any reactions _____ ?

Has the child taken antibiotics Y/N; For what _____

_____ ; Total number of courses of antibiotics to date: _____

Psychosocial Stressors

Any difficulties with lactation Y/N; Any behavioral problems Y/N Onset: _____

Any problems bonding Yes or No ; Any night terrors, sleepwalking, or difficulty sleeping Yes or No

Explain: _____ ; Age child began day care: _____

Does your child seem normal for their age Yes or No? Hours of TV a week? _____

Traumatic Stressors

Any traumas during pregnancy: _____

Any evidence of birth trauma (bruises, odd shaped head, stuck in birth canal, fast/slow delivery, respiratory distress, cord around

the neck, ect): _____

Any falls (couches, beds, changing tables, ect.) Y/N explain: _____

Any Traumas (bruising, cuts, stiches, fractures, ect.) _____

Any hospitalizations Y/N explain: _____

Any surgeries or organs removed Y/N explain: _____

Sports (list): _____ Age started: _____ Number or hours a week _____